WISCONSIN MEDICAID

PRIOR AUTHORIZATION / CHIROPRACTIC ATTACHMENT (PA/CA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Chiropractic Attachment (PA/CA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the provider who would perform/provide the requested service/procedure.

Element 2 — Address — Clinic or Office Where Service(s) is Provided
Enter the address of the clinic or office where chiropractic services are actually performed.

Element 3 — Wisconsin Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the chiropractor performing the service.

Element 4 — Telephone Number — Provider
Enter the telephone number, including area code, of the provider performing the service.

SECTION II — RECIPIENT INFORMATION

Element 5 — Name — Recipient
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 6 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 7 — Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION III — SERVICE INFORMATION

Element 8 — Total Number of Services Requested (Specify)
Enter the total number of visits/services requested.

Element 9 — Total Number of Weeks Requested
Enter the total number of weeks to complete requested visits.

Element 10 — Requested Start Date of Prior Authorization
Enter the date to begin services in MM/DD/YYYY format.

SECTION IV — SUPPORTING INFORMATION

Element 11 — Date of Spell of Illness
Enter the date the spell of illness (SOI) began in MM/DD/YYYY format.

Element 12 — Date of Beginning Treatment
Enter the first date of treatment for this SOI in MM/DD/YYYY format.

Element 13 — History

a. Initial — Explain history of initial treatment for recipient. (Leave blank if this SOI is initial treatment.)
b. Spell of Illness — Explain history for this SOI.
c. Previous and/or Concurrent Care — List previous or concurrent care relating to this SOI, if known.

Element 14 — Subjective Complaints

a. Initial — Explain initial complaints. (Leave blank if this SOI is initial treatment.)
b. Spell of Illness — Explain complaints relating to this SOI.

Element 15 — Objective Findings

a. Initial — Explain objective findings of initial treatment. (Leave blank if this SOI is initial treatment.)
b. Spell of Illness — Explain objective findings relating to this SOI.
c. Diagnosis — Enter the appropriate Medicaid-allowable diagnosis code.

Element 16 — Subjective Progress

Enter the subjective progress of the recipient. Are the frequency, intensity, distribution, and duration less? What has improved subjectively?

Element 17 — Objective Progress

Enter the objective progress of the recipient. What former positive tests are now negative or less positive?

Element 18 — Prognosis / Treatment Plan

Enter the prognosis and treatment plan for the recipient.

Element 19 — Additional Comments

Enter any additional comments that may assist the Medicaid medical consultants' decision in adjudicating the PA request. Examples include lifestyle choices, general health, or extenuating circumstances which slow the recipient's progress.

Elements 20 and 21 — SIGNATURE — Examining / Treating Provider and Date Signed

The examining or treating provider must sign this element. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.